

02706

2718

CERTIFICATE OF DEATH

Reg. Dist. No. 185

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. After this bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15 1-55 10M

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN	MARYLAND LENGTH OF STAY (in this place)	STATE CITY (If outside corporate limits, write RURAL and give nearest town) TOWN	COUNTY STREET ADDRESS (If rural give location)
24 Harford 24 Havre de Grace	4 hrs 30 min	Md North East	Cecil 07X-2
HOSPITAL OR INSTITUTION OR STREET ADDRESS	Harford Memorial Hosp General Delivery ✓		
3. NAME OF DECEASED (Type or Print)	(First)	(Middle)	(Last)
Baby Marsha			Ariazmendi
4. DATE OF DEATH	(Month)	(Day)	(Year)
March 8		1955	
S. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH
Female	Colored	newborn	March 8-1956
9. AGE last birthday yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)
IF UNDER 1 YEAR Months			Havre de Grace, Md.
IF UNDER 24 HRS. Days			
Hours			
Min.			
12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME		
Ruben G. Ariazmendi	Velora G. Wanzer		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)	16. SOCIAL SECURITY NO.		
(If Yes, give war or dates of service)			
17. INFORMANT & ADDRESS			
18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 762.0 IMMEDIATE CAUSE (A) <i>Atelectasis</i>			
ANTECEDENT CAUSE(S) DUE TO			
DISEASES OR CONDITIONS, IF ANY, (B) _____ GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) _____			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION		
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)	21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.	21a. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from....., 19....., to March 8, 1955, that I last saw the deceased alive on March 8, 1955, and that death occurred at 5:30PM, from the causes and on the date stated above.			
SIGNATURE <i>George J. Stansbury</i>		ADDRESS (Street, city, town, state) M.D. 569 Revolution St. Havre de Grace, Md. 3/8/55	
23. Cremation, (Specify)	DATE THEREOF 9 March 1955	NAME OF CEMETERY OR CREMATORI Harford Memorial Hospital	LOCATION (City, town, or county) Havre de Grace, Md.
24. REC'D BY REGISTRAR DATE	REGISTRAR'S SIGNATURE Mar. 15-1955 A. L. Lewis m.d. Henry R. Kelly Administrator		FUNERAL DIRECTOR'S SIGNATURE ADDRESS
2035295406			

BUREAU Y. S.

MAR 16 1955

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

02707

2719

CERTIFICATE OF DEATH

Reg. Dist. No. 185-

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

The bottom copy may be retained by the hospital or attending physician.

VS AISC 1-55 10M

1. PLACE OF DEATH COUNTY <u>Harford</u> CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN <u>Haure de Grace</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Harford Memorial Hospital</u>			2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Harford</u> Cecil CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Lising Sun</u> 07X-2 STREET ADDRESS (If rural give location)		
3. NAME OF DECEASED (First) <u>Dickie</u> (Middle) <u>Allen</u> (Last) <u>Brooks</u> (Type or Print)			4. DATE (Month) (Day) (Year) OF DEATH <u>MARCH 15 1955</u>		
S. SEX <u>Male</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH <u>MAR. 15 '55</u>	9. AGE last birthday - yrs. Months <u>2</u> Days <u>2</u> Hours <u>2</u> Min. <u>-</u>	IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>2</u> Days <u>2</u> Hours <u>2</u> Min. <u>-</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Newborn</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>No</u>	11. BIRTHPLACE (State or foreign country) <u>Md.</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>William Harley Brooks</u>			14. MOTHER'S MAIDEN NAME <u>Jewel Dean Key</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>No</u>		17. INFORMANT & ADDRESS <u>Father - Wm Brooks</u>	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <u>773.5</u> IMMEDIATE CAUSE (A) <u>Respiratory failure</u> ANTECEDENT CAUSE(S) DUE TO (B) <u>Extreme prematurity</u> DISEASES OR CONDITIONS, IF ANY, DUE TO (C) GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.					
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.					
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from 19 to 19 that I last saw the deceased alive on <u>15 March</u> , 19 <u>55</u> , and that death occurred at <u>7:30 A.M.</u> from the causes and on the date stated above. SIGNATURE <u>B. Penneur M.D.</u> DATE SIGNED <u>Mar 15 1955</u>					
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>3/19/55</u>		NAME OF CEMETERY OR CREMATORIAL <u>Haure de Grace</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>G. L. Lewis m.d.</u>		LOCATION (City, town, or county) <u>Wauhalla N.C.</u>	
DATE <u>Mar 16-1955</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Pennell for G. L. Lewis</u>		ADDRESS <u>Haure de Grace</u>	

2135213990

S18 CERTIFICATE OF DEATH

RECEIVED
FBI
MAR 15 1955

2720

CERTIFICATE OF DEATH

Reg. Dist. No. 185

1. PLACE OF DEATH

COUNTY HARFORD
 CITY (If outside corporate limits, write RURAL
 OR and give nearest town)
 TOWN HARVE de GRACE LENGTH OF STAY
 (in this place)

HOSPITAL OR
 INSTITUTION OR
 STREET ADDRESS 71 HARFORD Memorial Hspit

MARYLAND

(Length of stay)

2. USUAL RESIDENCE (HOME) OF DECEASED

STATE Maryland COUNTY Cecil

CITY (If outside corporate limits, write RURAL and give nearest town)

TOWN Rising Sun 07X-2

STREET
ADDRESS

(If rural give location)

3. NAME OF
DECEASED
(Type or Print)

(First) Vickie Lynn (Middle) (Last) Brooks

4. DATE (Month) (Day) (Year)
OF DEATH March 15 1955

5. SEX F

6. COLOR OR
RACE W7. SINGLE MARRIED,
WIDOWED, DIVORCED,
(Specify)

8. DATE OF BIRTH

15 March 1955

9. AGE last birthday

IF UNDER 1 YEAR
yrs. Months Days Hours Min.10a. USUAL OCCUPATION (Give kind of work
done during most of working life, even if
retired)

Newborn

10b. KIND OF BUSINESS
OR INDUSTRY

No

11. BIRTHPLACE (State or foreign country)

Md

12. CITIZEN OF WHAT
COUNTRY?

USA

13. FATHER'S NAME

William Harley Brooks

14. MOTHER'S MAIDEN NAME

Jewell Dean Key

15. WAS DECEASED EVER IN U. S. ARMED FORCES?

(Yes, no, or unk.) (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT & ADDRESS

Mother Wm. Brooks

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

18. MEDICAL CERTIFICATION

INTERVAL BETWEEN
ONSET AND DEATH

IMMEDIATE CAUSE (A)

ANTECEDENT CAUSE(S) DUE TO

DISEASES OR CONDITIONS, IF ANY, (B)

GIVING RISE TO THE ABOVE CAUSE DUE TO

STATING UNDERLYING CAUSE LAST. DUE TO (C)

Respiratory failure
Extreme prematurityII. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

2d. AUTOPSY?

YES NO 21a. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF DEATH
(If either, NOTIFY MEDICAL EXAMINER)21b. PLACE (Home, farm, factory,
OF INJURY street, office bldg., etc.)

21c. WHERE DID INJURY OCCUR? (City or town)

(County)

(State)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)

21e. INJURY OCCURRED
While at work Not while at work

21f. HOW DID INJURY OCCUR?

M.

22. I hereby certify that I attended the deceased from....., 19....., to....., 19....., that I last saw the deceased

alive on 15 March 1955, and that death occurred at 11:15 A.M. from the causes and on the date stated above.

SIGNATURE

ADDRESS (Street, city, town, state)

DATE SIGNED

M.D.

Harve de Grace Md 3/15/55

23. BURIAL, CREMATION,
REMOVAL (SPECIFY)

DATE THEREOF

NAME OF CEMETERY OR CREMATORIUM

LOCATION (City, town, or county)

(State)

Burial

3/19/55

Brooks

Mooresville N.C.

24. REC'D BY REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR'S SIGNATURE

ADDRESS

DATE Mar. 16-1955 G. L. Lewis M.D.

Signature of G. L. Lewis

MASSACHUSETTS DEPARTMENT OF HIGHLIGHTS

CERTIFICATE OF DEATH

BUREAU OF
RECEIVED
MR 18 19

NAME OF DECEASED	AGE	SEX	DEATH DATE	TIME	CAUSE OF DEATH	DEATH CERTIFICATE NUMBER
JOHN SMITH	65	M	1912-05-15	10:00 AM	Heart Disease	1234567890
ADDRESS OF DECEASED						
123 Main Street, Anytown, USA						
CITY, STATE, ZIP CODE						
Anytown, MA 01234						
PHONE NUMBER						
555-1234						
RELATIONSHIP TO DECEASED						
Son						
NAME OF DOCTOR						
Dr. John Doe						
SIGNATURE						
John Doe						

2736

CERTIFICATE OF DEATH

Reg. Dist. No. 181

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Harford CITY (If outside corporate limits, write RURAL OR and give nearest town) Aberdeen Rural		MARYLAND LENGTH OF STAY (in this place) 8 mos.,		STATE Maryland CITY (If outside corporate limits, write RURAL and give nearest town) Aberdeen, Rural,		COUNTY Harford STREET ADDRESS (If rural give location)	
3. NAME OF DECEASED (First) John (Middle) Harris (Last) Butschky (Type or Print)				4. DATE (Month) Mar. (Day) 6, (Year) 1955			
5. SEX male	6. COLOR OR RACE white	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) widowed	8. DATE OF BIRTH Aug. 22, 1884	9. AGE last birthday 70 yrs. 70	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Hours 0	IF UNDER 24 HRS. Days 0
10e. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Stationary Fireman			10b. KIND OF BUSINESS OR INDUSTRY Shoe Factory	11. BIRTHPLACE (State or foreign country) Balto., Co., Md.,	12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME John Henry Butschky				14. MOTHER'S MAIDEN NAME Louisa Long			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) no (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO. 218-12-2276 4			
17. INFORMANT & ADDRESS Mrs. Anna Mc Fadden, Aberdeen, R.D. Md.				18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 42.0.0 IMMEDIATE CAUSE (A) ACUTE LEFT VENTRICULAR FAILURE ANTECEDENT CAUSE(S) DUE TO (B) ARTERIOSCLEROTIC HEART DISEASE WITH 2 YEARS DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) GENERALIZED SEVERE ARTERIOSCLEROSIS PURPURIC HEART DISEASE WITH 2 YEARS PURPURIC HEART DISEASE WITH 2 YEARS				INTERVAL BETWEEN ONSET AND DEATH ABOUT			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. GANGRENE OF RT. FOOT (DRY)							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 3/4 , 19 55 , to 3/6 , 19 55 , that I last saw the deceased alive on 3/4 , 19 55 and that death occurred at 11 A.M. from the causes and on the date stated above. SIGNATURE <i>John Stewart Jr.</i> M.D. ADDRESS (Street, city, town, state) BOX 95, EDGEWOOD, MD DATE SIGNED 3/6/55							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF Mar. 5, 1955		NAME OF CEMETERY OR CREMATORIAL Moreland Memorial Park		LOCATION (City, town, or county) Baltimore, Maryland	
24. REC'D BY REGISTRAR DATE Mar. 9, 1955		REGISTRAR'S SIGNATURE <i>Nellie G. Perry</i>		25. FUNERAL DIRECTOR'S SIGNATURE Howard K. McComas & Son, Abingdon, Md., ADDRESS Howard K. McComas Jr.			

STATE OF CALIFORNIA - DIVISION OF HIGHWAY SAFETY

CERTIFICATE OF DEATH

BUREAU V.

MAR 10 195

DECEIVED

2721

02710

CERTIFICATE OF DEATH

Reg. Dist. No. 185-

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY HARFORD		MARYLAND		STATE Maryland		COUNTY HARFORD	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN HAURE de GRACE 24		2 DAYS		TOWN HAURE de GRACE		24	
HOSPITAL OR INSTITUTION OR STREET ADDRESS HARFORD Memorial Hosp.				STREET ADDRESS STAR Route			
3. NAME OF DECEASED (Type or Print) Alfred ALLEN Colburn				4. DATE (Month) OF DEATH MARCH 31, 1955			
5. SEX MALE	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) MARRIED	8. DATE OF BIRTH JULY 9, 1874	9. AGE last birthday yrs. 80	IF UNDER 1 YEAR Months		IF UNDER 24 HRS. Deys Hours Min.
10e. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NIGHT CLERK				10b. KIND OF BUSINESS OR INDUSTRY HOTEL		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Edward Colburn				14. MOTHER'S MAIDEN NAME MARY Brooks			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO. 212-32-4360		17. INFORMANT & ADDRESS Mrs. AYARILLA BALL COLBURN HAURE DE GRACE			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 177 X IMMEDIATE CAUSE (A) Carcinoma of Lungs ANTECEDENT CAUSE(S) DUE TO (B) Carcinoma of Lungs Beginning in DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) Pneumonia							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		18. MEDICAL CERTIFICATION INTERVAL BETWEEN ONSET AND DEATH			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.		21e. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 12-17, 1954, to 3-31, 1955, that I last saw the deceased alive on 3-31, 1955, and that death occurred at 6:30 P.M., from the causes and on the date stated above. SIGNATURE A. L. Lewis M.D. ADDRESS (Street, city, town, state) Haure de Grace Md. 4-2-55 DATE SIGNED							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		DATE THEREOF APRIL 3 '55		NAME OF CEMETERY OR CREMATORIUM TRINITY CHURCH Y.D. HARFORD		LOCATION (City, town, or county) (State) MD.	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE A. L. Lewis M.D.		25. FUNERAL DIRECTOR'S SIGNATURE R. Madison Mitchell		ADDRESS HAURE DE GRACE MD.	
DATE Apr. 2-55							

BUREAU V. S.

APR 4 1975

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

2737

CERTIFICATE OF DEATH

02711

182

Reg. Dist. No. 182

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY HARFORD		MARYLAND		STATE Md.		COUNTY HARFORD	
CITY (If outside corporate limits, write RURAL OR end give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN		STREET ADDRESS RURAL - WHITEFORD	
X TOWN RURAL - BELAIR		6 DAYS				(If rural give location)	
3. NAME OF DECEASED (Type or Print) BRYAN				4. DATE OF DEATH (Month) (Day) (Year) MAR. 9, 1955			
5. SEX M	6. COLOR OR RACE W	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) SINGLE	8. DATE OF BIRTH FEB 22, 1883	9. AGE last birthday 72	10. IF UNDER 1 YEAR yrs. Months	11. IF UNDER 24 HRS. Deys. Hours	12. IF UNDER 24 hrs. Min.
10e. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER				11. BIRTHPLACE (State or foreign country) MARYLAND			
13. FATHER'S NAME JAMES DONNAN				14. MOTHER'S MAIDEN NAME ELIZABETH LANE			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unk.) No				16. SOCIAL SECURITY NO. —			
17. INFORMANT & ADDRESS PAULINE COOPER, DELTA, PA.				18. MEDICAL CERTIFICATION CONGESTIVE HEART FAILURE			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 433.1				INTERVAL BETWEEN ONSET AND DEATH UNK.			
IMMEDIATE CAUSE (A) CONGESTIVE HEART FAILURE				ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, (B) GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) AURICULAR FIBRILLATION AND ARTERIO- OVER 2 mos SCLEROSIS.			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19e. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County)	(State)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from MARCH 5, 1955 , to MARCH 9, 1955 , that I last saw the deceased alive on 7 MARCH, 1955 , and that death occurred at 7:30 AM , from the causes and on the date stated above.							
SIGNATURE Philip W. Neuman ADDRESS (Street, city, town, state) M.D. 307 Hickory Bel Air Md 10 MARCH 55 DATE SIGNED							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		DATE THEREOF 3-11-55		NAME OF CEMETERY OR CREMATORIAL Mt. Nebo		LOCATION (City, town, or county) (State) DELTA Pa.	
24. REC'D BY REGISTRAR DATE 3-11-56		REGISTRAR'S SIGNATURE Francesca Louwod		25. FUNERAL DIRECTOR'S SIGNATURE John H. Hodson, Delta, Pa.		ADDRESS	

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that The bottom copy may be retained by the hospital or attending physician.

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **72 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

2722

02712

CERTIFICATE OF DEATH

Reg. Dist. No. 185

1. PLACE OF DEATH Harford County Maryland MARYLAND				2. USUAL RESIDENCE (HOME) OF DECEASED Maryland State Harford County Maryland					
24 CITY (If outside corporate limits, write RURAL OR end give nearest town) Havre de Grace		LENGTH OF STAY (in this place) Lifetime		CITY (If outside corporate limits, write RURAL end give nearest town) OR TOWN Havre de Grace		24 STREET ADDRESS (If rural give location) 815 Erie			
HOSPITAL OR INSTITUTION OR STREET ADDRESS 71 Harford Memorial				1					
3. NAME OF DECEASED (Type or Print) Rose B. Faltynowicz				4. DATE OF DEATH (Month) (Day) (Year) 3/17/55					
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH 4/12/1919	9. AGE last birthday 35 yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days	12. Hours Min.		
10e. USUAL OCCUPATION (Give kind of work done during most of working life, even if House Wife)				11. BIRTHPLACE (State or foreign country) Havre de Grace					
13. FATHER'S NAME Nick Benardi				14. MOTHER'S MAIDEN NAME Rachael Marrello					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) No				16. SOCIAL SECURITY NO. None					
17. INFORMANT & ADDRESS Mrs. Rachael Benardi, 815 Erie				18. MEDICAL CERTIFICATION I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH: 434.2 IMMEDIATE CAUSE (A) Cardiac Asthma ANTECEDENT CAUSE(S) DUE TO (B) Cerebral Embolus DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)				INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.									
19a. DATE OF OPERATION 0	19b. MAJOR FINDINGS OF OPERATION							20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)	21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)			21c. WHERE DID INJURY OCCUR? (City or town) 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. 21e. INJURY OCCURRED White <input type="checkbox"/> Not while at work <input type="checkbox"/> at work <input type="checkbox"/>			(County) (State)		
21f. HOW DID INJURY OCCUR?									
22. I hereby certify that I attended the deceased from <u>Mar. 10, 1955</u> , to <u>Mar. 17, 1955</u> , that I last saw the deceased alive on <u>Mar. 17, 1955</u> , and that death occurred at <u>11:30 P.M.</u> from the causes and on the date stated above. SIGNATURE <u>Charles J. Flynn</u> ADDRESS <u>400 W. Main Street, Havre de Grace, Md.</u> DATE SIGNED <u>3/17/55</u>									
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	DATE THEREOF 3/21/55	NAME OF CEMETERY OR CREMATORIAL Mt. Erin	LOCATION (City, town, or county) Havre de Grace, Md. (State)						
24. REC'D BY REGISTRAR DATE <u>Mar. 21-55</u>	REGISTRAR'S SIGNATURE <u>G. L. Lewis M.D.</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>Remington & Son</u>	ADDRESS Havre de Grace, Md.						

THE STATE OF IOWA - GATTITUDE

CERTIFICATE OF DEATH

9

BUREAU V. S.

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REGISTRY

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CERTIFICATE OF DEATH

Reg. Dist. No. 185-

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY HARFORD CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN HAURE DE GRACE		MARYLAND LENGTH OF STAY (in this place) 3 HRS 43 min.	STATE Maryland CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN HAURE DE GRACE
HOSPITAL OR INSTITUTION OR STREET ADDRESS HARFORD Memorial Hosp.		STREET ADDRESS 148 Bloomsbury Ave.	
3. NAME OF DECEASED (First) (Middle) (Last)		4. DATE (Month) (Day) (Year) OF DEATH MARCH 24, 1955	
MALE WHITE		SEX	FEARS
6. COLOR OR RACE		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) S	8. DATE OF BIRTH
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Maryland
13. FATHER'S NAME Erwin FEARS		14. MOTHER'S MAIDEN NAME Eleanor Elaine FADLEY	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.	
(If Yes, give war or dates of service)		17. INFORMANT & ADDRESS	
18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 759.3 IMMEDIATE CAUSE (A) RESPIRATORY FAILURE			
ANTECEDENT CAUSE(S) DUE TO CONGENITAL MAL DEVELOPMENT			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (B) DUE TO STATING UNDERLYING CAUSE LAST. (C) MAL DEVELOPMENT OF PLACENTA			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from 24 March, 1955, to 24 March, 1955, that I last saw the deceased alive on 24 March 1955, and that death occurred at 11⁴⁰ a.m., from the causes and on the date stated above. SIGNATURE RBN Ormeur M.D.			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) 3/25/52		DATE THEREOF NAME OF CEMETERY OR CREMATORIAL Harford Memorial Hospital	LOCATION (City, town, or county) Haure de Grace Md.
24. REC'D BY REGISTRAR DATE Mar. 27-1955 A. L. Lewis M. D.		REGISTRAR'S SIGNATURE	FUNERAL DIRECTOR'S SIGNATURE Harry R. Kelly Administrator
ADDRESS			

2035263392

DEPARTMENT OF STATE - BUREAU OF INTELLIGENCE

CERTIFICATE OF SECRET

BUREAU X

MAR 29 1955

RECEIVED

2738

02714

Reg. Dist.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 182

1
PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH: CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN <i>Wilma</i>		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <i>Md</i> COUNTY <i>Harford</i> CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN <i>Wilma</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Co</i>		STREET ADDRESS (If rural, give location) <i>1</i>	
3. NAME OF DECEASED: (Type or Print) <i>Thomas Edward Fisher</i>		(First) <i>Thomas</i> (Middle) <i>Edward</i> (Last) <i>Fisher</i>	4. DATE OF DEATH <i>March 29 1955</i>
5. SEX: <i>M</i>	6. COLOR OR RACE: <i>Cole</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <i>Marrried</i>	8. DATE OF BIRTH: <i>June 25, 1881</i>
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <i>Retired Farmer</i>		10b. KIND OF BUSINESS OR INDUSTRY: <i>Farmer</i>	9. AGE last birthday: <i>73</i> yrs. <i>73</i>
13. FATHER'S NAME: <i>Joseph Fisher</i>		11. BIRTHPLACE (State or foreign country): <i>Harford Co</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO.: <i>✓</i>	12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>
14. MOTHER'S MAIDEN NAME: <i>Mary Ellen (Fisher)</i>			
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH: <i>H22.1</i> Immediate cause (a) <i>Anterosclerotic CV disease</i> DUE TO Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (b) _____ (c) _____			INTERVAL BETWEEN ONSET AND DEATH
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION:	19b. MAJOR FINDING OF OPERATION:		
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, of street, office bldg., etc., INJURY	21c. (City or town) (County) (State)
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY M.	21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
SIGNATURE <i>Doreel C Palmer</i>		CHIEF MEDICAL EXAMINER DEPUTY MEDICAL EXAMINER ASSISTANT MEDICAL EXAM.	DATE SIGNED <i>3/29/55</i>
23. BURIAL, CREMATION, REMOVAL (Specify): <i>Burial</i>	DATE THEREOF <i>Mar 31/55</i>	NAME OF CEMETERY OR CREMATORIAL <i>Tabernacle Methodist</i>	LOCATION (City, town, or county) (State) <i>Benson Hartard Md</i>
DATE REC'D BY LOCAL REG. <i>3-30-55</i>	REGISTRAR'S SIGNATURE <i>Fuscilla Foword</i>	24. FUNERAL DIRECTOR <i>Joseph T Foster Bel Air Md</i>	ADDRESS

RECEIVED
BUREAU V. S.

APR 5 1955

2739

CERTIFICATE OF DEATH

Reg. Dist. No. 181

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY <input checked="" type="checkbox"/> CITY (If outside corporate limits, write RURAL OR end give nearest town) TOWN <input type="checkbox"/> HOSPITAL OR INSTITUTION OR STREET ADDRESS	Harford Churchville Churchville - Public Road	MARYLAND LENGTH OF STAY (in this place) of years	STATE Virginia COUNTY Culpeper CITY (If outside corporate limits, write RURAL and give nearest town) TOWN STREET ADDRESS Culpeper 83X.3 (If rural give location)
3. NAME OF DECEASED (Type or Print)		4. DATE (Month) OF DEATH	
(First) Bessie (Middle) Buckner (Last) Fitzhugh		Mar 3 1955	
5. SEX Female	6. COLOR OR RACE white	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed	8. DATE OF BIRTH Nov - 29th 1877
10e. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home	11. BIRTHPLACE (State or foreign country) Virginia
13. FATHER'S NAME Jessie H. Garth		14. MOTHER'S MAIDEN NAME Pruda Wayland	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? Yes, no, or unk. (If Yes, give war or dates of service) No		16. SOCIAL SECURITY NO. none	
17. INFORMANT & ADDRESS H 208 Preston St. O. Garth Fitzhugh Kensington Md.		17. INTERVAL BETWEEN ONSET AND DEATH 6 months	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 174x IMMEDIATE CAUSE (A) METASTATIC ADENOCARCINOMA ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (B) ADENOCARCINOMA, UTERUS STATING UNDERLYING CAUSE LAST (C) 2607		18. MEDICAL CERTIFICATION DIABETES MELLITUS	
19e. DATE OF OPERATION 2		19b. MAJOR FINDINGS OF OPERATION	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) 21e. INJURY OCCURRED M. While at work		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) 100 PARKE ST. ABERDEEN, MD. 3-355	
21f. HOW DID INJURY OCCUR?		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
22. I hereby certify that I attended the deceased from JAN 1953, to MARCH 3 1955, that I last saw the deceased alive on MARCH 2, 1955, and that death occurred at 4:00 PM, from the causes and on the date stated above. SIGNATURE Brown McDonald ADDRESS (Street, city, town, state) MARYLAND DATE SIGNED MARCH 3 1955			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal		DATE THEREOF 3/4/55	NAME OF CEMETERY OR CREMATORIY Lignum Cemetery
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE Ellie Q. Perry	LOCATION (City, town, or county) Lignum Virginia
DATE Mar 4-55		25. FUNERAL DIRECTOR'S SIGNATURE John G. Tarrung	ADDRESS Aberdeen, Md.

MARYLAND STATE DEPARTMENT OF HEALTH

2740

2411 N. Charles Street, Baltimore

02716

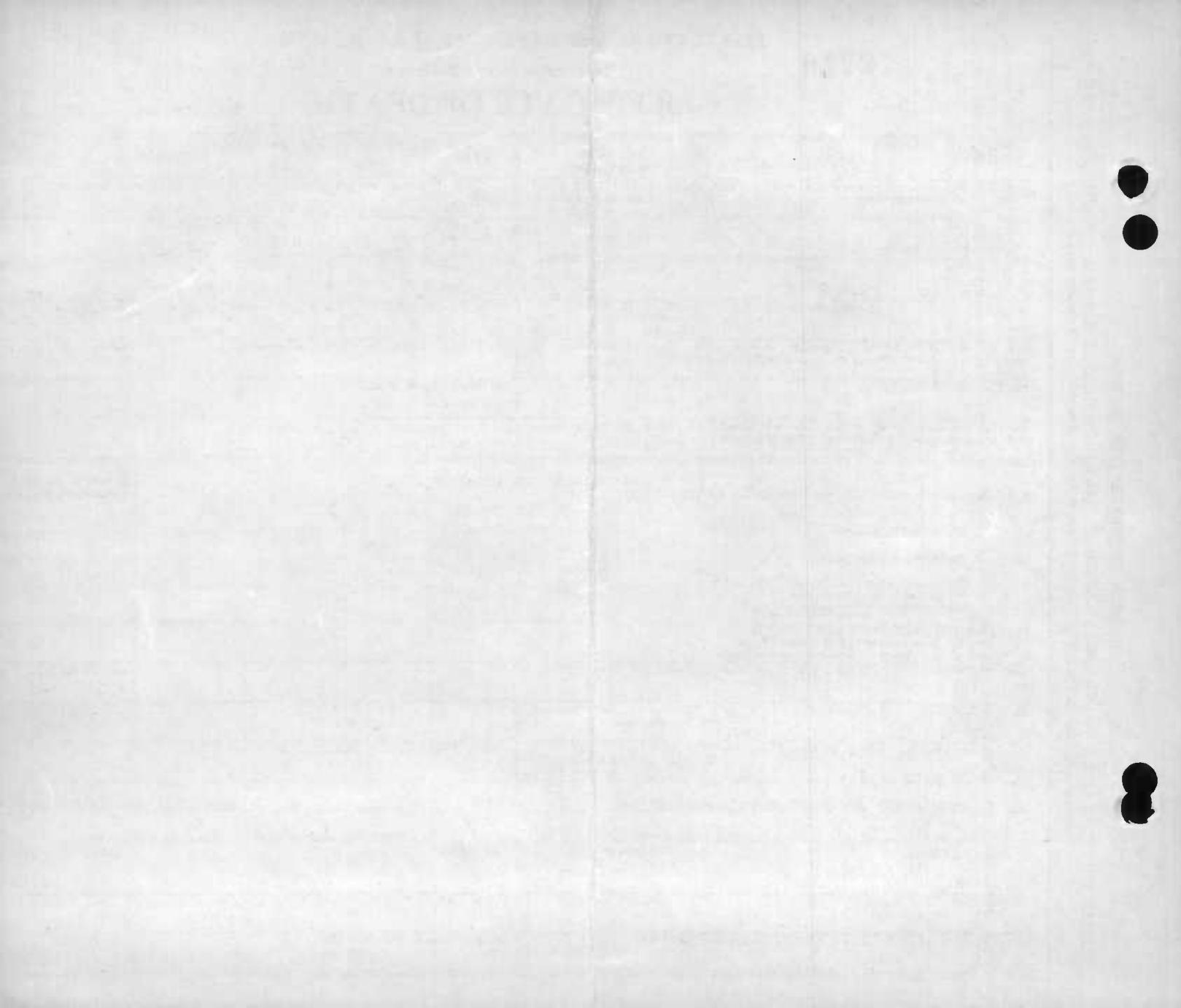
CERTIFICATE OF DEATH

Reg. Dist. No. 185

1. PLACE OF DEATH CITY OR TOWN HARFORD		2. USUAL RESIDENCE (HOME) OF DECEASED CITY OR TOWN MARYLAND JOPPA	
3. NAME OF DECEASED (Type or Print) MARION		4. DATE OF DEATH MAR. 31 1955	
5. SEX F	6. COLOR OR RACE W	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH 9-26-1869
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) MD.
13. FATHER'S NAME William C. BISCOE		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT AND ADDRESS Mrs. ADA L. Crouse - JOPPA - MD.			
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 33IX Immediate cause (a) CerebroVascular accident Antecedent cause(s) (b) Arterio sclerosis Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
21. ACCIDENT SUICIDE HOMICIDE INJURY		PLACE (Home, farm, factory, street, OF office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) OF INJURY	(Day) m.	INJURY OCCURRED While at Work <input type="checkbox"/> At work <input type="checkbox"/>	HOW DID INJURY OCCUR? DATE SIGNED
22. I hereby certify that I attended the deceased from 3-27, 1955, to 3-31, 1955, that I last saw the deceased alive on 3-28, 1955, and that death occurred at 5:20 p.m., from the causes and on the date stated above. SIGNATURE William A. Tyson M.D. Kingsville, Md. DATE SIGNED 4-1-55 NAME OF CEMETERY OR CREMATORIUM Chesterfield, LOCATION (City, town, or county) Centreville, Md.			
23. BURIAL, CREMATION REMOVAL (Specify) BURIAL		DATE 4-4-1955	
DATE REC'D BY LOCAL REG April 2, 1955		REGISTRAR'S SIGNATURE R.W.	
24. FUNERAL DIRECTOR G. Howard Strong 3207 W. North Ave		ADDRESS	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



2741

02717

Reg. Dist.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

No. 181

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH:

COUNTY HARFORD

MARYLAND

CITY (If outside corporate limits, write RURAL
OR and give nearest town)LENGTH OF STAY
(in this place)

TOWN ABERDEEN Proving Ground

HOSPITAL OR
INSTITUTION OR
STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE MARYLAND COUNTY CECIL

CITY (If outside corporate limits write RURAL and give nearest town)
OR

TOWN ELKTON RD 3

STREET
ADDRESS

(If rural, give location)

07X-2y

3. NAME OF
DECEASED:
(Type or Print)5. SEX:
MALE6. COLOR OR
RACE: WHITE7. SINGLE, MARRIED,
WIDOWED, DIVORCED,
(Specify): MARRIED8. DATE OF BIRTH:
MAY 5 19159. AGE last birthday:
3910a. USUAL OCCUPATION (Give kind of
work done during most of work life,
even if retired): Metal Cutter10b. KIND OF BUSINESS OR
INDUSTRY: Salvage

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT
COUNTRY?: USA13. FATHER'S NAME:
CHARLES FRANKLIN14. MOTHER'S MAIDEN NAME:
ESTHER REYNOLDS15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unk.) (If Yes, give war or dates of
service)

16. SOCIAL SECURITY NO.: 216-05-6086

17. INFORMANT & ADDRESS:
Margaret Franklin Elkton Rd 3 Md

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:
865X

Immediate cause

(a) DUE TO

Antecedent cause(s)

Diseases or conditions, if any,

(b) giving rise to the above cause DUE TO

stating underlying cause last

(c)

crushing dying chest

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION:

19b. MAJOR FINDING OF OPERATION:

20. AUTOPSY?

Yes No 21a. EXTERNAL CAUSE WAS
PRIMARY OR CONTRIBUTING CAUSE OF DEATH.21b. PLACE (Home, farm, factory,
OF street, office bldg., etc.,
INJURY APP)21c. (City or town)
(County) (State)

Aberdeen Harford 12 Md.

21d. TIME (Month) (Day) (Year) (Hour)
OF INJURY 3/26/55 10 A M.21e. INJURY OCCURRED
While at Not while
work at work21f. HOW DID INJURY OCCUR?
Airplane landing gear fell on him22. I hereby certify that I took charge of the remains described above, held an Autopsy , Inspection , Inquiry , andfind that death resulted from: Natural causes , Accident , Suicide , Homicide , Undetermined cause .

SIGNATURE Gerald C Palmer

CHIEF MEDICAL EXAMINER

DEPUTY MEDICAL EXAMINER

ASSISTANT MEDICAL EXAM.

DATE SIGNED

3/26/55

23. BURIAL, CREMATION,
REMOVAL (Specify): BurialDATE RECEIVED BY LOCAL
REG. March 30-55

REGISTRAR'S SIGNATURE Nellie G Jerry

24. FUNERAL DIRECTOR Joseph G Grant

ADDRESS North East, Md

RECEIVED

APP 1 1955

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH:

COUNTY

CITY (If outside corporate limits, write RURAL
OR and give nearest town)

MARYLAND

LENGTH OF STAY
(in this place)

TOWN

HOSPITAL OR
INSTITUTION OR
STREET ADDRESS3. NAME OF
DECEASED:
(Type or Print)

(First) Leo John

(Middle)

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE

CITY (If outside corporate limits write RURAL and give nearest town)

OR

TOWN

STREET

ADDRESS

COUNTY

Anne Arundel

(If rural, give location)

5209 Patrick Henry Drive

4. SEX:

Male

6. COLOR OR
RACE:

White

7. SINGLE, MARRIED,
WIDOWED, DIVORCED,
(Specify):

Married

July 6 1908

1908

10a. USUAL OCCUPATION (Give kind of
work done during most of work life,
even if retired):

Gas Lab Maintenance

- Taxi-Cab

Baltimore, Md

USA

10b. KIND OF BUSINESS OR
INDUSTRY:

11. BIRTHPLACE (State or foreign country):

12. CITIZEN OF WHAT
COUNTRY:

13. FATHER'S NAME:

Thomas

J. O'Grail

Mary (?)

14. MOTHER'S MAIDEN NAME:

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unk.)(If Yes, give war or dates of
service)

16. SOCIAL SECURITY NO.:

217-05-7534

ms. Mildred J. O'Grail (Name)

17. INFORMANT & ADDRESS:

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

819X

Immediate cause

(a)

DUE TO

Fracture skull

(b)

Diseases or conditions, if any,

giving rise to the above cause

DUE TO

stating underlying cause last

(c)

1800's and 1900's

A - 1800's

1800's and 1900's

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

CERTIFICATE OF DEATH

Reg. Dist. No. 185-

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY HARFORD		MARYLAND		STATE MD.		COUNTY HARFORD	
CITY (If outside corporate limits, write RURAL OR end give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN HAVRE DE GRACE		24	
TOWN HAVRE DE GRACE		25 YRS.		STREET ADDRESS 525 N. STOKES, ST.		(If rural give location)	
HOSPITAL OR INSTITUTION OR STREET ADDRESS 71		525 N. STOKES, ST.					
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
William ROBERT GRIMSEY				MAR. 22 1955			
S. SEX MALE	6. COLOR OR RACE WHITE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) MARRIED	8. DATE OF BIRTH FEB. 24, 1894	9. AGE last birthday 61	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Hours Min.	
10e. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FIREMAN Maintenance of Way PENN.				11. BIRTHPLACE (State or foreign country) PENN.			
13. FATHER'S NAME WILLIAM HENRY GRIMSEY				14. MOTHER'S MAIDEN NAME ELIZABETH TRIMBLE			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO. 717-07-5476		17. INFORMANT & ADDRESS Mrs. ETHEL D. GRIMSEY			
18. MEDICAL CERTIFICATION HAVRE DE GRACE, MD							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 422.2 IMMEDIATE CAUSE (A) <i>chronic Myocarditis & decompensation</i> ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, (B) GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
INTERVAL BETWEEN ONSET AND DEATH 10 days.							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. none							
19e. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21e. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) none			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 3-13, 1955, to 3-22, 1955, that I last saw the deceased alive on 3-22, 1955, and that death occurred at 9 P.M., from the causes and on the date stated above.							
SIGNATURE Joseph R. Solee M.D. ADDRESS (Street, city, town, state) DATE SIGNED 3-23-55							
23. BURIAL/CREMATION REMOVAL (SPECIFY) BURIAL		DATE THEREOF MAR. 25 1955		NAME OF CEMETERY OR CREMATORIAL ANGEL HILL		LOCATION (City, town, or county) HAVRE DE GRACE, MD. (State)	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE Mar. 25 1955		A. L. Lewis M.D.		F. Madison Mitchell		HAVRE DE GRACE, MD.	

BUREAU U. S.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11273 Reg. No. 185

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important.

1. PLACE OF DEATH: CITY TOWN	Maryland Hammond
CITY (If outside corporate limits, write RURAL OR and give nearest town)	LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS	10 yrs.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE CITY (If outside corporate limits write RURAL and give nearest town) TOWN	Maryland Hammond
STREET ADDRESS	(If rural, give location)

3. NAME OF DECEASED: (Type or Print)	(First) James	(Middle)	(Last) Harris	4. DATE OF DEATH	(Month) March	(Day) 1	(Year) 1955
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5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED,	8. DATE OF BIRTH:	9. AGE last birthday:	IF UNDER 1 YEAR	IF UNDER 24 HRS.		
Male	Negro	Unknown	Unknown	abt. 70 yrs.	Months	Days	Hours	Min.

10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Painter	Botts Expts.	Unknown	U.S.A.

13. FATHER'S NAME:	14. MOTHER'S MAIDEN NAME:
Unknown	Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unk.)	16. SOCIAL SECURITY NO.	17. INFORMANT & ADDRESS:
If Yes, give war or dates of service	33-183279	Welfare Board, Bel Air, Md.

18. MEDICAL CERTIFICATION	INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH: 422.1 Immediate cause (a) DUE TO Anteriosclerotic CV disease	

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last	(b) DUE TO	(c)
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II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.	
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19a. DATE OF OPERATION:	19b. MAJOR FINDING OF OPERATION:	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
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21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	21b. PLACE (Home, farm, factory, of street, office bldg., etc., INJURY	21c. (City or town) (County)	(State)
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21d. TIME (Month) (Day) (Year) (Hour) OF INJURY	M.	21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .

SIGNATURE	CHIEF MEDICAL EXAMINER DEPUTY MEDICAL EXAMINER ASSISTANT MEDICAL EXAM.	DATE SIGNED
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23. BURIAL, CREMATION, REMOVAL (Specify):	DATE THEREOF	NAME OF CEMETERY OR CREMATORIUM	LOCATION (City, town, or county)	(State)
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DATE REC'D BY LOCAL REG.	REG. Mar. 4-65	REG. A. F. Lewis M.D.	REG. Funeral Corp. of Maryland	ADDRESS
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RECEIVED
BUREAU V. S.

MAR 7 1955

2727

02721

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Reg. Dist.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No. 180-

1. PLACE OF DEATH: COUNTY <i>Maryland</i> CITY (If outside corporate limits, write RURAL OR and give nearest town) <i>Baltimore</i>		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <i>Maryland</i> COUNTY <i>Hoffman</i> CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN <i>Baltimore</i> 3401-4	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Hoffman Mem.</i>		LENGTH OF STAY (in this place) <i>2 mos</i>	
3. NAME OF DECEASED: (First) <i>Charles</i> (Middle) <i>Aileen</i> (Last) <i>Hoffman</i>		4. DATE OF DEATH <i>March 2</i> (Month) <i>March</i> (Day) <i>2</i> (Year) <i>55</i>	
5. SEX: <i>M</i>	6. COLOR OR RACE: <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>Single</i>	8. DATE OF BIRTH: <i>Sept 1927</i>
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired) <i>Rock Dancer</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>City Glass</i>	11. BIRTHPLACE (State or foreign country): <i>Pennsylvania</i>
13. FATHER'S NAME: <i>Charles A. Hoffman</i>		14. MOTHER'S MAIDEN NAME: <i>Guss Peacock</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <i>9</i>		16. SOCIAL SECURITY NO.: <i>17-12-1212</i>	
17. INFORMANT & ADDRESS: <i>Mary Wayfield</i> 2217 Christian St Baltimore Md		18. MEDICAL CERTIFICATION	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH: 812X Immediate cause (a) <i>Fracture skull</i> DUE TO Antecedent cause(s) Diseases or conditions, if any, (b) _____ giving rise to the above cause DUE TO stating underlying cause last (c) _____			
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH <i>Fracture pelvis</i>			
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:	
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY <i>House</i>)	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY <i>March 2 1955 9 A.M.</i>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR? <i>Auto accident antropolyte</i>			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> SIGNATURE <i>Gerald C Palmer</i>			
23. BURIAL, CREMATION, REMOVAL (Specify): <i>Cremation</i>		DATE THEREOF <i>3/5/55</i> NAME OF CEMETERY OR CREMATORIAL LOCATION (City, town, or county) <i>Baltimore Md. Mt. Olivet Baltimore Md.</i> (State)	
DATE REC'D BY LOCAL REG. <i>Mar 2-55</i>		REGISTRAR'S SIGNATURE <i>A. L. Lewis m.d.</i> 24. FUNERAL DIRECTOR <i>Harry H. Witzkie</i> ADDRESS <i>4101 Edmonson Ave</i>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct
age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
FEDERAL BUREAU OF INVESTIGATION

MAR 7 1955

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

2728

02722

CERTIFICATE OF DEATH

Reg. Dist. No. 185

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10/M

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY HARFORD	MARYLAND	STATE MARYLAND	COUNTY HARFORD
CITY (If outside corporate limits, write RURAL OR end give nearest town) HAURE DE GRACE	LENGTH OF STAY (in this place) 31 DAYS	CITY (If outside corporate limits, write RURAL and give nearest town) ABERDEEN	STREET ADDRESS Bush Chapel Road
HOSPITAL OR INSTITUTION OR STREET ADDRESS HARFORD MEMORIAL Hosp.			
3. NAME OF DECEASED (Type or Print)	(First) Thomas	(Middle) H	(Last) Hollingsworth
5. SEX MALE COLORED	6. COLOR OR RACE COLORED	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) MARRIED	8. DATE OF BIRTH 7-3-1867
10e. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER	10b. KIND OF BUSINESS OR INDUSTRY Farm	11. BIRTHPLACE (State or foreign country) MARYLAND	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Wm Henry Hollingsworth	14. MOTHER'S MAIDEN NAME Lisa Lisby		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) 4	16. SOCIAL SECURITY NO. 4		
17. INFORMANT & ADDRESS Mrs. Hattie Christy - Perryman, Md.			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 177X IMMEDIATE CAUSE		18. MEDICAL CERTIFICATION Carcinoma of Prostate	
ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (A) (B) (C)		Azotemia with Cardiac Failure	
		Arteriosclerotic Heart disease	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION 0		19b. MAJOR FINDINGS OF OPERATION Car	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.	
21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from 2/27 , 19 55 , to 3/30 , 19 55 , that I last saw the deceased alive on 3/30 , 19 55 , and that death occurred at 10:10 p.m. from the causes and on the date stated above. SIGNATURE <i>George J. Stanbury, M.D.</i> ADDRESS <i>569 Revolution St, Havre de Grace, Md.</i> DATE SIGNED <i>3/31/55</i>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 4/2/55	NAME OF CEMETERY OR CREMATORIAL Union Methodist Cemetery, Aberdeen, Md.
24. REC'D BY REGISTRAR Apr. 1-1955 G. L. Lewis, M.D.		REGISTRAR'S SIGNATURE <i>G. L. Lewis, M.D.</i>	LOCATION (City, town, or county) (State)
DATE Apr. 1-1955		25. FUNERAL DIRECTOR'S SIGNATURE <i>Otelia J. Bullock, Havre de Grace, Md.</i>	ADDRESS

DEPARTMENT OF HEALTH-STATE OF OREGON

CERTIFICATE OF DEATH

DEATH CERTIFICATE

NAME OF DECEASED PERSON

ADDRESS

NAME OF DOCTOR

AGE
SEX
RACE
MATERIAL TESTED

TESTS
EXAMINER

CAUSE OF DEATH
TIME OF DEATH
DATE OF DEATH

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BUREAU V. S.

1955

JULY

RECEIVED

2729

CERTIFICATE OF DEATH

Reg. Dist. No. 185-

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY 24 HARFORD	MARYLAND	STATE Maryland	COUNTY Harford
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN HAURE de Grace	LENGTH OF STAY (in this place) 3 days	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN JOPPA	X (If rural give location)
HOSPITAL OR INSTITUTION OR STREET ADDRESS 11 HARFORD Memorial Hospital		STREET ADDRESS	
3. NAME OF DECEASED (First) Miles (Middle) Olney (Last) Howell		4. DATE (Month) (Day) (Year) OF DEATH March 22 1955	
5. SEX M	6. COLOR OR RACE W	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	B. DATE OF BIRTH 8/11/1902
10b. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) AS. Lot.		10b. KIND OF BUSINESS OR INDUSTRY Lat. Mechanic	9. AGE last birthday 52 yrs.
13. FATHER'S NAME P. G. Howell		11. BIRTHPLACE (State or foreign country) North Carolina	12. CITIZEN OF WHAT COUNTRY? USA
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) No		16. SOCIAL SECURITY NO. 212-18-0546	14. MOTHER'S MAIDEN NAME Adeline Hammon
17. INFORMANT & ADDRESS Mrs. Arbutus G. Howell, Joppa, Md.		18. MEDICAL CERTIFICATION	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 6920 IMMEDIATE CAUSE (A) Acute Staphylococcal Septicemia from		INTERVAL BETWEEN ONSET AND DEATH 3 days	
ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, (B) Acute Staph. Cellulitis of face		10 days	
GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Secondary Anemia -- Nutritional origin ??		??	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21c. WHERE DID INJURY OCCUR? (City or town) (County)		(State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> at work <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from March 15 1955, to March 22, 1955, that I last saw the deceased alive on Mar. 22, 1955, and that death occurred at 12:15 P.M., from the causes and on the date stated above. SIGNATURE Willard P. Hudson, M.D.			
ADDRESS (Street, city, town, state)		DATE SIGNED 3-24-55	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF Mar. 25, 1955 NAME OF CEMETERY OR CREMATORIAL Oak Grove,	
24. REC'D BY REGISTRAR DATE Mar. 25, 1955		REGISTRAR'S SIGNATURE A. L. Lewis, M.D.	
25. FUNERAL DIRECTOR'S SIGNATURE Howard K. McComas & Son, Abingdon, Md., Howard K. McComas, Jr.		ADDRESS	

CERTIFICATE OF DEATH

NAME		ADDRESS	
MR.	JOHN	STREET	NUMBER
LAST	DOE	CITY	STATE
MIDDLE	JOHN	ZIP CODE	PHONE NUMBER
CITY AND STATE OF BIRTH			
DATE OF DEATH			
CAUSE OF DEATH			
DEATH CERTIFICATION			
I declare under penalty of perjury that the information contained in this certificate is true and correct to the best of my knowledge and belief.			
Signature			
Date			

BUREAU V.E.
RECEIVED
MAR 28 1955

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

2742

CERTIFICATE OF DEATH

02724

Reg. Dist. No. 181

INSTRUCTIONS
TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death.
The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY X Harford		MARYLAND		STATE Baltimore Maryland		COUNTY (Harford) Pachman	
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN Aberdeen		LENGTH OF STAY (in this place) Nine hours		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Havre de Grace		(If rural give location) STREET ADDRESS Pulaski Trailer Park 53x-3	
HOSPITAL OR INSTITUTION OR STREET ADDRESS U S Army Hospital Aberdeen Proving Ground Md							
3. NAME OF DECEASED (First) Michael Leroy Johnson (Type or Print)				4. DATE (Month) (Day) (Year) OF DEATH Mar 8 1955			
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Single	8. DATE OF BIRTH 20 Nov 1954	9. AGE last birthday yrs. 3	10. IF UNDER 1 YEAR Months 18	11. IF UNDER 24 HRS. Days Hours Min.	
10e. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None			10b. KIND OF BUSINESS OR INDUSTRY None	11. BIRTHPLACE (State or foreign country) Maryland			12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Robert Lewis Johnson				14. MOTHER'S MAIDEN NAME Elaine Marie Jordan			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? No	16. SOCIAL SECURITY NO. None		17. INFORMANT & ADDRESS Father Robert L Johnson Pulaski Trailer Pk Havre de Grace Md				
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 330X IMMEDIATE CAUSE Sub-acute aneurysm hemorrhage spontaneous ANTECEDENT CAUSE(S) DUE TO anterior? DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (A) Sub-acute aneurysm hemorrhage spontaneous (B) (C) 				INTERVAL BETWEEN ONSET AND DEATH 9 hrs.			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION			20. AUTOPSY? YES X NO 			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)			21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.	21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 7 March , 1955, to 8 March , 1955, that I last saw the deceased alive on 8 March , 1955, and that death occurred at 1:30 a.m. from the causes and on the date stated above. SIGNATURE <i>Richard Allen</i>				ADDRESS (Street, city, town, state) US ARMY HOSP APG MD DATE SIGNED 8 March 1955			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	DATE THEREOF 3-12-55	NAME OF CEMETERY OR CREMATORIAL Memorial Cemetery			LOCATION (City, town, or county) Oelwein Iowa		
24. REC'D BY REGISTRAR March 9, 1955	REGISTRAR'S SIGNATURE Hillis G. Perry	25. FUNERAL DIRECTOR'S SIGNATURE Penninger & Son Havre de Grace, Md.			ADDRESS		
DATE March 9, 1955	20X4172384						

CERTIFICATE OF DEATH

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ANSWER

RECEIVED
LIBRARY

2743

CERTIFICATE OF DEATH

Reg. Dist. No. 180

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY CITY (If outside corporate limits, write RURAL OR end give nearest town) TOWN		Harford Maryland Length of stay (in this place)		STATE Maryland CITY (If outside corporate limits, write RURAL and give nearest town) TOWN		County Harford Abingdon (If rural give location)	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>00</i>				STREET ADDRESS <i>X</i>			
3. NAME OF DECEASED (First) Edward M. Lee				4. DATE (Month) OF DEATH March 15 1955			
S. SEX male	6. COLOR OR RACE colored	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) married	8. DATE OF BIRTH July, 1, 1879	9. AGE last birthday 75 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Deys	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Trackman			10b. KIND OF BUSINESS OR INDUSTRY Railroad	11. BIRTHPLACE (State or foreign country) Abingdon, Maryland			12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Robert E. Lee				14. MOTHER'S MAIDEN NAME Evelyn Hanson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <i>No</i>			16. SOCIAL SECURITY NO. 705-09-7402	17. INFORMANT & ADDRESS Bertha Lee, Abingdon, Maryland.			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <i>420.0</i> IMMEDIATE CAUSE (A) <i>Uremia</i> ANTECEDENT CAUSE(S) DUE TO <i>Arteriosclerotic heart disease</i> DISEASES OR CONDITIONS, IF ANY, (B) GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
INTERVAL BETWEEN ONSET AND DEATH							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19e. DATE OF OPERATION <i>0</i>		19f. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED M. While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>2/27</i> , 1955, to <i>3/15</i> , 1955, that I last saw the deceased alive on <i>3/14</i> , 1955, and that death occurred at <i>8:30 p.m.</i> from the causes and on the date stated above. SIGNATURE <i>George J. Stanbury</i> ADDRESS (Street, city, town, state) <i>M.D. 569 Revolution St. Havre de Grace, Md.</i> DATE SIGNED <i>3/19/55</i>							
23. BURIAL, CREMATION REMOVAL (SPECIFY) <i>Burial</i>		DATE THEREOF <i>Mar. 19, 1955</i>		NAME OF CEMETERY OR CREMATORIAL <i>John Wesley</i>		LOCATION (City, town, or county) <i>Abingdon, Harford, Md.</i>	
24. REC'D BY REGISTRAR DATE <i>March 19, 1955</i>		REGISTRAR'S SIGNATURE <i>Norma S. Moore</i>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <i>Howard K. McCormack & Son Abingdon, Md.</i>			

S-19 CERTIFICATE OF DEATH

Date:

Place of Death:

Cause of Death:

Signature:

Name of Hospital:

Signature:

Name of Doctor:

Signature:

Mr. James
Fitzgerald

BUREAU V. S.

Date: 21st 1955
Place: 22nd MAR 22 1955Fitzgerald, James
Signature:

FEGELEY

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

2730

CERTIFICATE OF DEATH

02726

Reg. Dist. No. 185-

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY <i>Harford</i>	MARYLAND	STATE <i>MD.</i>	COUNTY <i>OEC 1/</i>
CITY (If outside corporate limits, write RURAL OR and give nearest town) <i>Harford de Grace</i>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>Northeast MD 07x2</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>71 HARFORD Mem. Hosp.</i>		STREET ADDRESS <i>WALLACE Ave.</i>	
3. NAME OF DECEASED (First) <i>Robert</i>		(Middle) <i>Charles</i>	
		(Last) <i>Loynds</i>	
4. DATE (Month) March 11		(Year) 19 55	
5. SEX M	6. COLOR OR RACE W	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH 9-20-1906
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <i>Pipe Fitter</i>		10b. KIND OF BUSINESS OR INDUSTRY Aberdeen Prov. G	11. BIRTHPLACE (State or foreign country) <i>Holland PA</i>
13. FATHER'S NAME <i>Walter Loynds</i>		14. MOTHER'S MAIDEN NAME <i>Laura Stilley</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) No		16. SOCIAL SECURITY NO. 179-07-0299	
17. INFORMANT & ADDRESS Sarah E. Loynds, North East Md		18. MEDICAL CERTIFICATION	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 162X IMMEDIATE CAUSE (A) <i>Bronchogenic Cancer</i> ANTECEDENT CAUSE(S) DUE TO _____ DISEASES OR CONDITIONS, IF ANY, (B) _____ GIVING RISE TO THE ABOVE CAUSE _____ STATING UNDERLYING CAUSE LAST. DUE TO _____ (C) _____			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION 21		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH 6 months	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21c. WHERE DID INJURY OCCUR? (City or town) _____ (County) _____ (State) _____		21d. TIME OF INJURY (Month) (Month) (Day) (Day) (Year) (Year) (Hour) (Hour) M. _____	
21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from Sept 15, 19 55 , to March 11, 19 55 , that I last saw the deceased alive on 11 March 19 55 , and that death occurred at 1040 A.M. from the causes and on the date stated above. SIGNATURE <i>E.J. Simon</i> ADDRESS (Street, city, town, state) <i>Harford Grace</i> DATE SIGNED 3-11-55			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 3-15-55	NAME OF CEMETERY OR CREMATORIAL Lawncroft
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <i>L. Lewis m.d.</i>	LOCATION (City, town, or county) Delaware Co., Pa
DATE Mar. 16-55		25. FUNERAL DIRECTOR'S SIGNATURE <i>Joseph R. Grant</i>	
		ADDRESS North East, Md	

BUREAU V. S.

MAR 16 1955

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

2731

CERTIFICATE OF DEATH

Reg. Dist. No. 185

112727

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C-55 10M

1. PLACE OF DEATH COUNTY <i>Harford</i> CITY (If outside corporate limits, write RURAL OR end give nearest town) TOWN <i>HAURE de Grace</i>		MARYLAND LENGTH OF STAY (in this place) <i>2 hrs</i>	2. USUAL RESIDENCE (HOME) OF DECEASED STATE <i>md</i> CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>Haute de Grace</i>	COUNTY <i>Harford</i> (If rural give location) <i>324 Superior St - 1</i>		
3. NAME OF DECEASED (Type or Print) <i>Baby Girl</i>		(First) <i>Baby</i> (Middle) <i>Girl</i> (Last) <i>Ross</i>	4. DATE OF DEATH <i>Mar 7 1955</i>	(Month) <i>Mar</i> (Day) <i>7</i> (Year) <i>1955</i>		
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i></i>	8. DATE OF BIRTH <i>3-7-55</i>	9. AGE last birthday yrs. <i>2</i>	IF UNDER 1 YEAR Months <i>0</i> Days <i>0</i> Hours <i>0</i> Min. <i>0</i>	IF UNDER 24 HRS. Hours <i>0</i> Min. <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i></i>		10b. KIND OF BUSINESS OR INDUSTRY <i></i>	11. BIRTHPLACE (State or foreign country) <i>Maryland</i>	12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		
13. FATHER'S NAME <i>Walter Lawrence Ross</i>		14. MOTHER'S MAIDEN NAME <i>Edna Mabel Curry</i>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <i>No</i> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i></i>	17. INFORMANT & ADDRESS <i></i>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <i>Pneumonia</i>						
IMMEDIATE CAUSE (A) <i>Pneumonia</i>						
ANTECEDENT CAUSE(S) DUE TO <i></i>						
DISEASES OR CONDITIONS, IF ANY, (B) GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <i></i>						
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <i></i>						
19e. DATE OF OPERATION <i>0</i>		19b. MAJOR FINDINGS OF OPERATION <i></i>		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <i></i>		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) <i></i>		21c. WHERE DID INJURY OCCUR? (City or town) <i></i> (County) <i></i> (State) <i></i>		
21d. TIME OF INJURY (Month) <i>0</i> (Day) <i>0</i> (Year) <i>1955</i> (Hour) <i>0</i> M. <i>0</i>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <i></i>		
22. I hereby certify that I attended the deceased from <i>3/7, 1955</i> , to <i>3/7, 1955</i> , that I last saw the deceased alive on <i>3/7, 1955</i> , and that death occurred at <i>2:01 PM</i> , from the causes and on the date stated above.						
SIGNATURE <i>Frederick J. Tolson</i> M.D. ADDRESS (Street, city, town, state) <i>17 White St., Dept. 301, Md.</i> DATE SIGNED <i>3/8/55</i>						
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i></i>		DATE THEREOF <i>3/9/55</i>	NAME OF CEMETERY OR CREMATORIAL <i>Harford Memorial Hospital</i>	LOCATION (City, town, or county) <i>Haute de Grace, Md.</i> (State) <i></i>		
24. REC'D BY REGISTRAR DATE <i>Mar. 11-1955</i>		REGISTRAR'S SIGNATURE <i>A. L. Lewis, M.D.</i>	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <i>Henry R. Kelly, administrator</i>			

2035295200

02728

2744

182

CERTIFICATE OF DEATH

Reg. Dist. No.

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY <i>X Black Horse</i>	MARYLAND CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Black Horse ada</i>	LENGTH OF STAY (in this place)	STATE <i>Md.</i> CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN STREET ADDRESS <i>Black Horse White Hall Rd,</i>
3. NAME OF DECEASED (First) <i>Mary</i> (Middle) <i>Carl</i> (Last) <i>Saunders</i> (Type or Print)		4. DATE OF DEATH <i>Mar 26 1955</i>	
S. SEX <i>Female</i>	6. COLOR OR RACE <i>col.</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>s.</i>	B. DATE OF BIRTH <i>Feb-16 1905</i>
10e. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <i>-</i>	9. AGE last birthday <i>0</i> IF UNDER 1 YEAR yrs. <i>1</i> Months <i>0</i> Days <i>0</i> Hours <i>0</i> Min. <i>0</i>
13. FATHER'S NAME <i>Hillard</i>		11. BIRTHPLACE (State or foreign country) <i>Hause de Groce</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <i>9</i>		14. MOTHER'S MAIDEN NAME <i>Alma A. Jackson</i>	
16. SOCIAL SECURITY NO. <i>-</i>		17. INFORMANT & ADDRESS <i>alma a. Saunders white hall rd</i>	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
75IX IMMEDIATE CAUSE (A) <i>MENINGOCOLE</i>			
ANTECEDENT CAUSE(S) DUE TO			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (B) _____			
STATING UNDERLYING CAUSE LAST. DUE TO (C) _____			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19e. DATE OF OPERATION <i>0</i>		19f. MAJOR FINDINGS OF OPERATION	
21e. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <i>21. 19. 1963 10</i>		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)	
21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from , 19....., to , 19....., that I last saw the deceased alive on , 19....., and that death occurred at A.M., from the causes and on the date stated above.			
SIGNATURE <i>Derald E Palmer</i>		ADDRESS (Street, city, town, state) <i>Deputy Medical Examiner County 3/26/55</i>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		DATE THEREOF <i>3-28-65</i>	
24. REC'D BY REGISTRAR		NAME OF CEMETERY OR CREMATORIUM <i>Mt Joy</i>	
DATE <i>3. 30-65</i>		LOCATION (City, town, or county) <i>Montgomery Rd Md.</i>	
REGISTRAR'S SIGNATURE <i>Rosilla Lowood</i>		25. FUNERAL DIRECTOR'S SIGNATURE <i>Mark E. St. John</i>	
ADDRESS <i>Montgomery Rd, Gaithersburg, Md.</i>		ADDRESS <i>Montgomery Rd, Gaithersburg, Md.</i>	

CERTIFICATE OF DEATH

HARRISON

WILLIE

EDWARD HARRISON
MURKIN HARRISON

HARRISON

EDWARD HARRISON

EDWARD HARRISON 1769 MARY

EDWARD HARRISON 0 0

EDWARD HARRISON -

EDWARD HARRISON -

WENDELDORF

BUREAU V. S.

APR 1 1955

RECEIVED
GENERAL STATE INSURANCE OF MICHIGAN - DETROIT

74

BUREAU 3-38-22 MI 202

GENERAL STATE INSURANCE OF MICHIGAN - DETROIT

2745

CERTIFICATE OF DEATH

Reg. Dist. No. 182

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY <i>X</i> Harford	MARYLAND TOWN Fallston	STATE Penna CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN Pittston	COUNTY Luzerne (If outside corporate limits, write RURAL and give nearest town) STREET ADDRESS 10 Rock St. (If rural give location)
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>FD. D#2 Box 83</i>	LENGTH OF STAY (In this place) <i>6 months</i>		
3. NAME OF DECEASED (Type or Print) <i>Christopher Conrad Schultz</i>		4. DATE OF DEATH <i>Mar. 6 1955</i>	
S. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>MARRIED</i>	B. DATE OF BIRTH <i>Mar. 15 1895</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Carpenter</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Construction</i>	11. BIRTHPLACE (State or foreign country) <i>Penna.</i>
13. FATHER'S NAME <i>Christopher Schultz</i>		14. MOTHER'S MAIDEN NAME <i>Katherine Svartz</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <i>No</i>		16. SOCIAL SECURITY NO. <i>195-90-8310</i>	
17. INFORMANT & ADDRESS <i>Betty Mair</i>		18. MEDICAL CERTIFICATION <i>PULMONARY ODEMA ADENO CARCINOMA OF ESOPHAGUS WITH METASTASIS TO LIVER</i>	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <i>150X IMMEDIATE CAUSE (A) PULMONARY ODEMA ANTECEDENT CAUSE(S) DUE TO ADENO CARCINOMA OF ESOPHAGUS DISEASES OR CONDITIONS, IF ANY, (B) GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) WITH METASTASIS TO LIVER</i>			
INTERVAL BETWEEN ONSET AND DEATH <i>6 MOS</i>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
ABOUT 2 YEAR			
19a. DATE OF OPERATION <i>DEC 14 1953</i>		19b. MAJOR FINDINGS OF OPERATION <i>ADENO CARCINOMA OF ESOPHAGUS</i>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) <i>Bel Air, Md</i>	
21c. WHERE DID INJURY OCCUR? (City or town) <i>(County)</i>		(State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <i>M. at work</i>		21e. INJURY OCCURRED While Not while at work at work	
21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>AUGUST 19 54</i> to <i>MARCH 6 1955</i> , that I last saw the deceased alive on <i>MARCH 3 1955</i> , and that death occurred at <i>8:20 AM</i> , from the causes and on the date stated above.			
SIGNATURE <i>Philip W. Herman</i>		ADDRESS (Street, city, town, state) <i>M.D. 307 Hickory, Bel Air, Md</i>	
DATE SIGNED <i>MARCH 6 1955</i>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		DATE THEREOF <i>Mar 10 1955</i>	
NAME OF CEMETERY OR CREMATORIUM <i>Hughes Town Southern</i>		LOCATION (City, town, or county) <i>Pittston Pa. Luzerne Co.</i>	
24. REC'D BY REGISTRAR <i>Priscilla Lowood</i>		REGISTRAR'S SIGNATURE <i>Priscilla Lowood</i>	
DATE 3-12-55		25. FUNERAL DIRECTOR'S SIGNATURE <i>John Archer Benson Md</i>	
ADDRESS			

DEPARTMENT OF JUSTICE - FEDERAL BUREAU OF INVESTIGATION

CERTIFICATE OF DEATH

SEARCHED AND SERIALIZED

SEARCHED

SEARCHED
INDEXED

BUREAU U. S.

MAR 16 1955

RECEIVED

02730

MARYLAND 2746

STATE DEPARTMENT OF HEALTH

Reg. Dist. No. 182

CERTIFICATE OF DEATH

1. PLACE OF DEATH COUNTY <i>Harrowd</i>		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <i>Penna</i>	
CITY or outside corporate limits, write RURAL and give nearest town <i>Bell Air Rural</i>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <i>Phila</i>	
HOSPITAL OR INSTITUTION STREET ADDRESS <i>Walter's Nursing Home</i>		STREET ADDRESS <i>75 x -3</i>	
3. NAME OF DECEASED (Type or Print)	(First) <i>George</i>	(Middle) <i>Seitter</i>	4. DATE OF DEATH <i>March 8</i>
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED <i>Marrried</i>	8. DATE OF BIRTH <i>March 13, 1873, 81</i>
10a. USUAL OCCUPATION (Give kind of work done during past of working life, even if retired) <i>Retired</i>		9. AGE last birthday yrs. <i>81</i>	
10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Phila Penna U.S.A.</i>	
13. FATHER'S NAME <i>Eis Z Seitter</i>		12. CITIZEN OF WHAT COUNTRY <i>U.S.A.</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>mr mr</i>	
17. INFORMANT AND ADDRESS <i>Mrs Charles Schlight Phila, Penna</i>		18. MEDICAL CERTIFICATION I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <i>Arteriosclerosis CVDisease</i>	
422.1 Immediate cause		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	
Antecedent cause(s)		TIME (Month) (Day) (Year) (Hour) INJURY OCCURRED OF INJURY m. While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, of office bldg., etc.) INJURY	
(CITY OR TOWN)		(COUNTY)	
(STATE)		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
22. I hereby certify that I attended the deceased from <i>March 1, 1955</i> , to <i>March 8, 1955</i> , that I last saw the deceased alive on <i>March 8, 1955</i> , and that death occurred at <i>3 P.m.</i> , from the causes and on the date stated above. SIGNATURE <i>Gerald C Palmer M.D.</i> ADDRESS <i>Bell Air Rd.</i> DATE SIGNED <i>3/8/55</i>			
23. BURIAL Cremation DATE REMOVAL (Specify) <i>removed March 9, 1955</i>		NAME OF CEMETERY OR INCINERATOR <i>North Cedar Hill, Phila, Penna.</i>	
DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE REC. <i>March 10, 1955 C. G. Kirk</i>		LOCATION City, town, or county (State) 24. FUNERAL DIRECTOR ADDRESS <i>Charley Kester 609 East Allegheny Ave. Penna</i>	

BUREAU Y. S.

MAR 16 1955

REGISTRATION

2732

02731

CERTIFICATE OF DEATH

Reg. Dist. No. 180-

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been excused by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY CITY (If outside corporate limits, write RURAL OR end give nearest town) TOWN	Harpaid MARYLAND Hare-de-Grae 24 hrs	STATE CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN	Md. COUNTY Harpaid Hare-de-Grae 24
HOSPITAL OR INSTITUTION OR STREET ADDRESS	Length of Stay (In this place)	STREET ADDRESS	(If rural give location)
24 Hare-de-Grae 24 hrs	24 hrs	35030 S. Wash. St.	
3. NAME OF DECEASED (Type or Print)	(First) Joyce Louise (Middle) (Last) Sparks.	4. DATE OF DEATH 3/14/55	
S. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Newborn	8. DATE OF BIRTH 3/13/53
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Newborn	10b. KIND OF BUSINESS OR INDUSTRY Newborn	11. BIRTHPLACE (State or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME Norman Sparks.	14. MOTHER'S MAIDEN NAME Agnes Walter.		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)	16. SOCIAL SECURITY NO.	17. INFORMANT & ADDRESS Hospital records	
18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 761.5 IMMEDIATE CAUSE (A) RESPIRATORY FAILURE INTERVAL BETWEEN ONSET AND DEATH 2 HRS ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, (B) EXTREME PREMaturity GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO STATING (C) SEPARATION OF PLACENTA - (BIRTH WEIGHT 2' 1/2")			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION		
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH <input type="checkbox"/> (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. el work	21e. INJURY OCCURRED While Not while at work	21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from 13 MAR 1955, to 14 MAR 1955, that I last saw the deceased alive on 14 MAR 1955, and that death occurred at 5:20 P.M., from the causes and on the date stated above. SIGNATURE B.B. Nemeth ADDRESS (Street, city, town, state) DATE SIGNED 3/14/55			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	DATE THEREOF 3/15/55	NAME OF CEMETERY OR CREMATORIAL Angel Dell	LOCATION (City, town, or county) Maryland
24. REC'D BY REGISTRAR DATE Mar. 16 - 1955 - G. L. Lewis m.d.	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR'S SIGNATURE	
ADDRESS			
DATE Mar. 16 - 1955 - G. L. Lewis m.d.			
2035183270			

BUREAU V.

MAR 18 1955

RECEIVED

CERTIFICATE OF DEATH

159

NAME	AGE	SEX	DEATH DATE	DEATH PLACE	CAUSE OF DEATH	DEATH CERTIFICATE NUMBER
JOHN D. HANCOCK	55	Male	Mar 18, 1955	Hospital	Heart Disease	159-123456789
This certificate is issued under the authority of the State Department of Health - Albany, New York.						
The undersigned, being duly sworn, deposes and says that the above information is true to the best of his knowledge and belief.						
Signed: JOHN D. HANCOCK						
Attest: ALBANY STATE DEPARTMENT OF HEALTH - ALBANY, NEW YORK						

INSTRUCTIONS

To ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death.

To FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC I-55 10/M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

2747

CERTIFICATE OF DEATH02732
182

Reg. Dist. No.

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
1. COUNTY <i>Harford</i>	MARYLAND	STATE <i>Md</i>	COUNTY <i>Harford</i>
CITY (If outside corporate limits, write RURAL OR and give nearest town) <i>X Arlington</i>	LENGTH OF STAY (in this place) <i>6 year</i>	CITY (If outside corporate limits, write RURAL and give nearest town) <i>X Arlington</i>	TOWN <i>Arlington</i>
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>20</i>	STREET ADDRESS <i>(If rural give location)</i>		
3. NAME OF DECEASED (Type or Print) <i>John Avery Stainback</i>		4. DATE OF DEATH MARCH 7, 1955	
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>Married</i>	8. DATE OF BIRTH <i>Sept. 12, 1876</i>
9. AGE last birthday <i>78 yrs.</i>	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if railroad) <i>Retired Farmer</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>Potomac, Va</i>	11. BIRTHPLACE (State or foreign country) <i>Potomac, Va U.S.A</i>
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A</i>	13. FATHER'S NAME <i>Unknown</i>	14. MOTHER'S MAIDEN NAME <i>Unknown</i>	15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <i>No</i>
16. SOCIAL SECURITY NO. <i>212-22-2508</i>	17. INFORMANT & ADDRESS <i>John Coolen Darlington, Md.</i>	18. MEDICAL CERTIFICATION <i>Old Age</i>	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <i>794X</i>	IMMEDIATE CAUSE <i>(A)</i>	INTERVAL BETWEEN ONSET AND DEATH <i>14y</i>	
ANTECEDENT CAUSE(S) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. <i>DUE TO</i>	DUE TO <i>(B)</i>		
	<i>(C)</i>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION <i>0</i>	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)	21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21c. WHERE DID INJURY OCCUR? (City or town) <i>Md</i>	(County) <i>Md</i>
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <i>M.</i>	21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? <i>GP</i>	(State) <i>Md</i>
22. I hereby certify that I attended the deceased from March 19, 1955, to March 19, 1955, that I last saw the deceased alive on March 6, 1955, and that death occurred at GP, M, from the causes and on the date stated above.			
SIGNATURE <i>Malcolm Nudley Phillips</i>		ADDRESS (Street, city, town, state) <i>Darlington Md</i>	DATE SIGNED <i>3/11/55</i>
23. BURIAL, CREMATION, REMOVAL SPECIFY <i>Burial</i>	DATE THEREOF <i>March 10, 1955</i>	NAME OF CEMETERY OR CREMATORIUM <i>Churchville Cem</i>	LOCATION (City, town, or county) <i>Harford Co, Md.</i>
24. REC'D BY REGISTRAR <i>March 19, 1955, G. Kirk, H. Bailey</i>	REGISTRAR'S SIGNATURE <i>Kirk, H. Bailey</i>	25. FUNERAL DIRECTOR'S SIGNATURE <i>John Avery Stainback</i>	ADDRESS <i>Arlington</i>
DATE <i>March 19, 1955</i>			

RECEIVED BY THE GOVERNMENT OF INDIA - PARLIAMENT

CERTIFICATE OF DEATH

BUREAU Y. S.

MAR 16 1955

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

2733

02733

CERTIFICATE OF DEATH

Reg. Dist. No. 185-

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

1. PLACE OF DEATH COUNTY HARFORD CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN HAVRE DE GRACE		MARYLAND LENGTH OF STAY (in this place) 1/2 HR.	2. USUAL RESIDENCE (HOME) OF DECEASED STATE Maryland COUNTY HARFORD CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN ABERDEEN 31 STREET ADDRESS (If rural give location) 12 HANOVER
3. NAME OF DECEASED (Type or Print) CECILIA		(First) (Middle) (Last) CECILIA Summers	4. DATE OF DEATH MARCH 26 1955
5. SEX FEMALE Colored	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Divorced	8. DATE OF BIRTH FEB. 8, 1909 46
10e. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10b. KIND OF BUSINESS OR INDUSTRY Home Helper	9. AGE last birthday yrs. Months Days Hours Min. 46 0 0 0 0
13. FATHER'S NAME Cicero A. Summers		11. BIRTHPLACE (State or foreign country) Virginia	12. CITIZEN OF WHAT COUNTRY? U.S.A.
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO. 226-20-7650	17. INFORMANT & ADDRESS CATHERINE SUMMER BROWN RICHMOND, VA.
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 443X IMMEDIATE CAUSE (A) Cerebral Hemorrhage ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, (B) Congestive Heart Failure GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) Hypertensive Cardiovascular disease		INTERVAL BETWEEN ONSET AND DEATH 14hr.	
18. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
22. I hereby certify that I attended the deceased from Dec. 19 54, to March 26, 1955, that I last saw the deceased alive on March 24, 1955, and that death occurred at 2:45 P.M., from the causes and on the date stated above. SIGNATURE George J. Stansbury, M.D. 569 Revolution St, Havre de Grace, Md. 3/26/55 ADDRESS (Street, city, town, state) DATE SIGNED			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		DATE THEREOF Mar. 29 55	NAME OF CEMETERY OR CREMATORIAL ST. JAMES
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE G. L. Lewis M.D.	LOCATION (City, town, or county) (State) HAVRE DE GRACE, Md.
DATE Mar. 28-1955		25. FUNERAL DIRECTOR'S SIGNATURE R. Madison Mitchell HAVRE DE GRACE ADDRESS	

STATE GOVERNMENT OF NEBRASKA

CERTIFICATE OF DEATH

BUREAU Y. S.
RECEIVED
MAR 29 1955

MARYLAND STATE DEPARTMENT OF HEALTH--BALTIMORE, 18

2735

02734

CERTIFICATE OF DEATH

185-

Reg. Dist. No.....

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death.

The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

INSTRUCTIONS

1. PLACE OF DEATH COUNTY <i>Harford</i> MARYLAND CITY (If outside corporate limits, write RURAL OR end give nearest town) <i>Havre de Grace</i> TOWN <i>8 min.</i> LENGTH OF STAY (In this place) HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Hospital Memorial</i>				2. USUAL RESIDENCE (HOME) OF DECEASED STATE <i>Md.</i> COUNTY <i>Harford</i> CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>Havre de Grace</i> STREET ADDRESS <i>Pulaski Traffer Court</i> (If rural, give location)			
3. NAME OF DECEASED (First) <i>Baby Boy</i> (Middle) <i>Thompson</i> (Last)				4. DATE OF DEATH <i>March 5 1955</i>			
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>Single</i>	8. DATE OF BIRTH <i>3/5/55</i>	9. AGE last birthday yrs. <i>0</i>	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>None</i>			10b. KIND OF BUSINESS OR INDUSTRY <i>None</i>	11. BIRTHPLACE (State or foreign country) <i>Md.</i>	12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME <i>John Thompson</i>				14. MOTHER'S MAIDEN NAME <i>Clara Lent</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <i>No</i> (If Yes, give war or dates of service) <i>none</i>				16. SOCIAL SECURITY NO. <i>none</i>			
17. INFORMANT & ADDRESS <i>Hosp. Funds</i>							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 776X IMMEDIATE CAUSE (A) <i>Prematurity</i> ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, (B) _____ GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) _____							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19e. DATE OF OPERATION <i>0</i>		19b. MAJOR FINDINGS OF OPERATION					
21e. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <i>3/5 1955</i> M. <i>at work</i>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>3/5 1955</i> to <i>3/5 1955</i> , that I last saw the deceased alive on <i>3/5 1955</i> , and that death occurred at <i>11:05 AM</i> , from the causes and on the date stated above. SIGNATURE <i>Frederick J. Harten</i> M.D. ADDRESS <i>17th & Park Blv. Aberdeen, Md.</i> DATE SIGNED <i>3/5/55</i> 23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i> DATE THEREOF <i>3/6/55</i> NAME OF CEMETERY OR CREMATORIUM <i>Anglo Dell</i> LOCATION (City, town, or county) <i>Havre de Grace, Md.</i> (State) 24. REC'D BY REGISTRAR <i>Mar. 6-1955 G. L. Lewis M. D.</i> REGISTRAR'S SIGNATURE <i>G. L. Lewis M. D.</i> FUNERAL DIRECTOR'S SIGNATURE <i>Funeral Director</i> ADDRESS <i>Funeral Director</i> DATE <i>2035264220</i>							

BUREAU V. S.
MAY 8 1955

2000

02735

2734

CERTIFICATE OF DEATH

Reg. Dist. No. 185

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

death certificate

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY CITY (If outside corporate limits, write RURAL OR end, give nearest town) TOWN		MARYLAND LENGTH OF STAY (in this place)		STATE CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN		Maryland COUNTY HARFORD PERRYMAN Md. x	
24 Hove de Grace		2 hrs		STREET ADDRESS		(If rural give location)	
71 Hove de Grace 2 hrs HARFORD Memorial Hospital							
3. NAME OF DECEASED (Type or Print)		(First) (Middle) (Last)		4. DATE OF DEATH		(Month) (Day) (Year)	
DENNIS LeRoy WARFIELD				Mar. 13		1955	
5. SEX Male		6. COLOR OR RACE Col		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)		8. DATE OF BIRTH March 13, 1955	
9. AGE last birthday — yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Charles WARFIELD				14. MOTHER'S MAIDEN NAME Katie Martha Christy			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS Mother - PERRYMAN Md		INTERVAL BETWEEN ONSET AND DEATH (Incompatible)	
95% IMMEDIATE CAUSE (A) DUE TO				18. MEDICAL CERTIFICATION Bilateral Congenital Kidney disease (with life)			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION 21		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21c. WHERE DID INJURY OCCUR? (City or town) (County), (State)							
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 13 March 1955 to 13 March 1955, that I last saw the deceased alive on 13 March 1955, and that death occurred at 5:45 A.M., from the causes and on the date stated above. SIGNATURE George J. Stansbury, M.D. ADDRESS (Street, city, town, state) DATE SIGNED 3/14/55							
23. BURIAL / CREMATION - REMOVAL (SPECIFY)		DATE THEREOF 3/13/55		NAME OF CEMETERY OR CREMATORIAL HARFORD Memorial Hospital		LOCATION (City, town, or county) Hove de Grace, Md. (State)	
24. REC'D BY REGISTRAR DATE Mar. 16 - 1955		REGISTRAR'S SIGNATURE G. L. Lewis M. D. Harry R. Tully Administrator		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	

(stationary) event such that λ has a stationary distribution.

BUREAU A.L.

MAR 16 1955